Exhibit F

Affidavit of Carl Rowe

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

JOHN P. POLCASTRO, SR.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Civil Action No. 1:05-cv-00909-MEF-VPM**
	)	
GREG WARD, et al.,	)	
	)	
Defendants.	)	

AFFIDAVIT OF CARL ROWE

STATE OF ALABAMA	)
	)
COUNTY OF GENEVA	)

BEFORE ME, the undersigned authority and Notary Public in and for said County and State at large, personally appeared Carl Rowe, who being known to me and being by me first duly sworn on oath deposes and says as follows:

1. My name is Carl Rowe. I am over the age of nineteen and competent to make this affidavit. I am the Jail Administrator for the Geneva County Detention Facility.

2. I am familiar with the Plaintiff due to his being incarcerated in the Geneva County Detention Facility.

3. I state affirmatively that I neither acted, nor caused anyone to act, in such a manner as to deprive the Plaintiff of any right to which he was entitled.

4. The Geneva County, Alabama Sheriff's Department operates the Geneva County Detention Facility pursuant to sound policies and procedures which ensure that the rights of all inmates incarcerated therein are respected. Members of the jail staff are trained both in house and at certified training programs and academies regarding all aspects of their jobs, including the administration of medical care to inmates.

5. It is the policy of the Geneva County, Alabama Sheriff's Department that all inmates confined in the Geneva County Detention Facility be entitled to a level of health care comparable to that available to the citizens in the surrounding community in order that the inmates' physical and emotional well-being may be maintained. All medical care rendered to inmates in the Geneva County Detention Facility is delivered under the direction of a licensed health care practitioner. It is departmental policy that no member of the jail staff, or any other Sheriff's Department employee, may ever summarily or arbitrarily deny an inmate's reasonable request for medical services. All judgments regarding the necessity of medical treatment are left to a licensed health care practitioner

6. It is the policy of the Geneva County Sheriff's Department that all inmates incarcerated in the Geneva County Detention Facility be allowed to request health care services at any time. Requests of an emergency nature may be made either verbally or in writing, but all requests for non-emergency care from state or county inmates must be submitted in writing. Members of the jail staff are charged with the responsibility of accepting requests for medical treatment from inmates and taking appropriate action to see that those requests are dealt with in a prompt and appropriate manner. Inmates with non-emergency medical problems are taken to see Dr. O.D. Mitchum in Geneva, Alabama. Inmates who have an emergency medical problem are taken to the Emergency Room for treatment. At no time did the Plaintiff request, either written or verbal, medical attention for any of his claims that are basis of his Complaint.

7. When a member of the jail staff receives a request for medical treatment from an inmate, it is his or her responsibility to turn that request form over to the responsibility of the on duty jailer or matron. It is then the on duty jailer or matron's responsibility to make an appointment for the inmate with an appropriate health care provider. Any doubt as to whether an

actual need exists for medical treatment is resolved in favor of the inmate, with medical services being offered. All requests of an emergency nature are handled immediately.

8. It is the policy of the Geneva County Sheriff's Department that persons incarcerated in the Geneva County Detention Facility be entitled to safe and accurate dispensation and administration of prescription and nonprescription medication. All medication prescribed for an inmate by a health care provider during the time of an inmate's incarceration is obtained by the Sheriff's Department and distributed according to the doctor's directions. When distributing medications, members of the jail staff complete a medication log, which records the inmate's name, the medication, the date and time it was delivered, the initials of the officer delivering the medication, or supervising its delivery, and the inmate's initials or signature acknowledging receipt.

9. I have never denied necessary medical care or treatment to Plaintiff or any other inmate.

10. Plaintiff was taken to the Wiregrass Emergency Room on August 1, 2005. He was also taken to see O.D. Mitchum on August 25, 2005. Dr. Mitchum ordered X-Rays; therefore, Plaintiff was taken to the Hospital for X-rays.

11. The Geneva County Detention Facility is subject to routine maintenance and repairs on a regular basis by the custodian.

12. All inmates, including the Plaintiff, are always provided with a mattress and bed linens for sleeping in the event that the number of inmates exceeds the number of beds at the jail. Never has the Plaintiff had to sleep on the floor without a mattress and bed linens.

13. Inmates are regularly given cleaning materials to use.

14. Inmates are regularly given privileges such as exercise time and/or smoke breaks.

15. All meal preparation is supervised by a Geneva County staff member.

16. It is the policy of the Geneva County Sheriff's Department that only the minimal amount of force necessary will be used on an arrestee or inmate.

17. Internal grievance procedures at the Geneva County Detention Facility are available to all inmates. It is the policy of the Geneva County Detention Facility that inmates are permitted to submit grievances and that each grievance will be acted upon accordingly. Inmates are given an inmate grievance form upon their request to complete and return to a detention center staff member for any grievance they may have. It is further the policy and procedure of the Geneva County Detention Facility to place each such grievance in the inmate's file for a record of the same.

18. Upon my review of the Plaintiff's inmate file, there is no grievance filed by him, and I have not received a grievance from the Plaintiff concerning the allegations made the basis of his Complaint. Had I received such a grievance, I would have followed procedures and responded to the grievance accordingly.

19. I was never in the possession of any cash money that was allegedly taken from Plaintiff's home, nor was I ever present at Plaintiff's home.

20. Inmates are given access to their attorneys as well as reasonable opportunity to use the Jail's law library. Materials for writing and mailing letters are available for purchase by inmates in the jail.

21. I certify and state that the documents from Plaintiff's Inmate File provided to the Court which are attached to the Defendants' Special Report are true and correct copies of these records, kept at the Geneva County Detention Facility in the regular course of business. I am the Custodian of these Records.

22. I swear, to the best of my present knowledge and information, that the above statements are true, that I am competent to make this affidavit, and that the above statements are made by drawing from my personal knowledge of the situation.

CARL ROWE

SWORN TO and **SUBSCRIBED** before me this 29th day of November, 2005.

NOTARY PUBLIC
My Commission Expires: My Commission Expires 4/8/07

Exhibit G

Affidavit of Donald Weeks

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

JOHN P. POLCASTRO, SR.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**Civil Action No. 1:05-cv-00909-MEF-VPM**
	)	
GREG WARD, et al.,	)	
	)	
Defendants.	)	

AFFIDAVIT OF DONALD WEEKS

STATE OF ALABAMA	)
	)
COUNTY OF GENEVA	)

BEFORE ME, the undersigned authority and Notary Public in and for said County and State at large, personally appeared Donald Weeks, who being known to me and being by me first duly sworn on oath deposes and says as follows:

1. My name is Donald Weeks. I am over the age of nineteen and competent to make this affidavit. I am employed with the Geneva County Detention Facility as a jailer and have been for 11 years. Before that I was Assistant Chief of Police in Samson, Alabama, for 8 years.

2. I am familiar with the Plaintiff due to his being incarcerated in the Geneva County Detention Facility.

3. I state affirmatively that I neither acted, nor caused anyone to act, in such a manner as to deprive the Plaintiff of any right to which he was entitled.

4. I have never denied necessary medical care or treatment to Plaintiff or any other inmate.

5. On August 31, 2005, I called Dr. Mitchum's office and learned that Plaintiff's test results were normal and that everything is fine.

6. I was never in the possession of any cash money that was allegedly taken from Plaintiff's home, nor was I ever present at Plaintiff's home.

7. I have not received a grievance from the Plaintiff concerning the allegations made the basis of his Complaint.

8. I swear, to the best of my present knowledge and information, that the above statements are true, that I am competent to make this affidavit, and that the above statements are made by drawing from my personal knowledge of the situation.

DONALD WEEKS

SWORN TO and **SUBSCRIBED** before me this 14th day of November, 2005.

NOTARY PUBLIC
My Commission Expires: My Commission Expires 4/8/07

Exhibit H

Wiregrass Medical Center Record dated August 1, 2005

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP
HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
BALDASTRO SANTANGER	R	E.R.							

20. RP	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
	517533 MCLEOD JIMMY W [illegible] 52 MALE			

25. C OMPLAINT 26	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES
10/21/05					

OUTPATIENT SURGERY INFORMATION

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
[illegible]		

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____
- ☐ Tetanus Toxiod given _____ 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bedmay go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS 1) Follow ABC HEAD INJURY INSTRUCTIONS 2) MONO CHECK EVERY 2 HOURS

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE [signature] NURSE'S SIGNATURE [signature] RN PHYSICIAN'S SIGNATURE

SCHOOL AND WORK EXCUSE PATIENT NAME DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

Exhibit I

O.D. Mitchum, M.D. Record dated August 25, 2005

O.D. MITCHUM, M.D.
100 W. LAKE PROFESSIONAL PARK, STE. ONE
GENEVA, AL 36340
(334) 684-9400

OFFICE VISITS - EST. PT.		VACCINES		REMOVAL F.B. EYE	65205
MINIMAL	99211	FLU - G0008	90659	FINE NEEDLE BIOPSY BREAST	19100
PROB FOCUS	99212	PNEUMONIA - G0009	90732	INGROWN NAIL REMOVAL	11730
EXPD PROB FOCUS	99213	TETANUS - 90471	90703	IRRIGATION EARS	69210
DETAIL / LC	99214	ADM / INJECTION	90782	TRIGGER POINT INJ.	20550
COMP / MC	99215	ADM / ANTIBIOTIC INJECTION	90788	INJ/ASP - SM.JT.	20600
				INTERN. JT	20605
		LABORATORY		MAJ JT.	20610
OFFICE VISITS - NEW PT		BASIC METABOLIC PANEL	80048		
PROB FOCUS	99201	GENERAL HEALTH PANEL	80050		
EXPD PROB FOCUS	99202	ELECTROLYTE PANEL	80051	RADIOLOGY	
DETAIL / LC	99203	COMPREHENSIVE METABOLIC	80053	ANKLE	73600
COMP / MC	99204	LIPID PANEL	80061	ABDOMEN	74000
		ARTHRITIS PANEL (RH9)		CERVICAL SPINE	72040
		ACUTE HEPATITIS PANEL	80074	CHEST / FRONTAL / 1 VIEW	71010
PREV MED EST PT		HEPATIC FUNCTION PANEL	80076	ELBOW	73070
18-39 YRS	99395	ANEMIA I PROFILE	31000	FINGER	73140
40-64 YRS	99396	VENIPUNCTURE - G0001	36415	FOOT	73620
65 & OLDER	99397	GLUCOSE	82947	FOREARM	73090
		HCT	85013	HAND	73120
PREV MED NEW PT		HEMOCCULT	82270	HIP / SINGLE / 1 VIEW	73500
18-39 YRS	99385	HEMOC. SCREENING	G0107	HIP / SINGLE /2 VIEWS	73510
40-64 YRS	99386	PSA	84153	HIP / BIL / 2 VIEWS	73520
65 & OLDER	99387	PAP SMEAR	88150	KNEE	73560
		PAP SMEAR SCREENING	Q0091	LEG	73590
INJECTIONS		TINE TEST	8658*	LUMBAR SPINE	72100
AMPICILLIN 500MG	J0290	URINALYSIS	81000	PELVIS	72170
B12 (UP TO 1000 MG)	J3420	URINE PREGNANCY	81025	SHOULDER	73020
CELESTONE (3MG)	J0702	Tsh	84443	SINUS	76080
ESTROGEN	J1390	T4	84439	SKULL	70250
DEPO. PROVERA 100 MG	J1055	CBC	85025	THORACIC SPINE	72070
ROCEPHIN (250 MG)	J0696	HgBAIC	83036	WRIST	73100
IRON DEXTRAN (2CC) 50MG	J1750	B-12 LEVEL	82607	EKG	93005
VISTARIL (UP TO 25 MG)	J3410			EKG	93010
SOLGANAL (UP TO 50 MG)	J2910				
DEPOTESTOSTERONE 100MG	J1070				
DEPOTESTOSTERONE 200MG	J1080	PROCEDURES			
KENALOG (10MG)	J3301	I.&D. SIMPLE	10060		
		I.&D. COMPLICATED	10061		
		EXCISION - LESION	11xxx		
		HYFRECATION - LESION	1700x		

Diagnosis				Next Appt.
1	Contusion	5		
2		6		RX's
3		7		
4		8		

Special Orders

Signature

O.D. Mitchum, MD_____

Acc: 0009B0044-01 GENEVA COUNTY COMMISSION
Seq: 021063 PD: 1 ATTN: DONNA JONES
Dat: 08/25/05 14:04 PO BOX 430
Sts: RP- PP GENEVA AL 36340

Ins: (none)
Col. Bal: $0.00
Acc. Bal: $1,131.00
Charges:
Paid:

Exhibit J

Medical Records from Wiregrass Medical Center dated August 1, 2005

STATE OF ALABAMA)

GENEVA COUNTY)

CERTIFICATION OF RECORDS

I, Jean Morris, of the office of the Wiregrass Medical Center, do hereby certify that the documents annexed are a true copy from the original records of John P. Polcastro, Sr., SSN: 096-44-7848, DOB 05/02/53, which are authorized by law to be and are, in fact, made and maintained in the regular and ordinary course of business and on file at the office of the Wiregrass Medical Center and in its legal custody.

Executed this 23rd day of November, 2005.

Jean Morris

Sworn to and subscribed before me this 23rd day of Nov., 2005.

(SEAL)

Notary Public
My Commission Expires:

MY COMMISSION EXPIRES
AUGUST 27, 2008

MY COMMISSION EXPIRES
AUGUST 27, 2008

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECOR

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
517533	3	PALCASTRO SANTANGER	52	5/02/1953	M	SH	8/01/05	22:35	VVB

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
517 COMMERCE ST		GENEVA	AL	36340	334-684-5670

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
096447848	NONE GIVEN			

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE
		8/01/05	HOME/OTHER ACCID
		TIME	EVENT
			INJ TO BODY

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
PALCASTRO SANTANGER	517 COMMERCE ST	GENEVA	AL	36340	684-5670

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
INMATE AT CO JAIL			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
			096447848	MCLEOD J W/

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the "Administrator of Hospital" to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the "Controller" of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH

M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE

M.D.

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

517533 Rolasto Santanger

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 8-1- 20 05

Witness Vinda Bain

Pam Baine R

Patient's mark

Patient

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date _____ Signature _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date _____ Signature _____ Relationship to Patient _____

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name	PALCASTRO, SANTANGER	Discharge Date	08/02/2005
Admission Date	08/01/2005	Date of Birth	05/02/1953
Medical Record Number	096447848	Sex	Male
Age	52		
Account Number	517533		

DX	Code	DX Description
1	919.0	Abras/Friction Burn w/o Infect Site Mult/NOS
2	873.40	Open Wound Face Site NOS
3	E960.0	Unarmed Fight/Brawl

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... 006900

Consulting Physician.....

Discharge Disposition..... 01 - Home

DRG =

Status.....

Memo

DRG

MDC Weight AMLOS GMLOS LOS

PRINT DATE: 08/03/05 902
Ed Benak M.D.
Medical Director
TIME: 13:00

Wiregrass Medical Center
1200 W. Maple Ave
Geneva, AL 36340-1642
LABORATORY --- CUMULATIVE REPORT

PAGE 1
01D0304961
CLIA Number
H5LACUMV

NAME.: PALCASTRO SANTANGER
ACCT#: 517533
ROOM.: E.R. - NO PENDING ORDERS

SEX.....: M
AGE.....: 52 Y
DOB.....: 05/02/1953
PAT. PHONE: 3346845670

PHY..: MCLEOD JIMMY W MD
ADMIT: 08/01/05
MR#..: 096447848

CHEMISTRY

	08/01/05 2325	REFERENCE RANGE	UNITS
SODIUM	139	136 - 145	meq/L
POTASSIUM	4.5	3.5 - 5.1	meq/L
CHLORIDE	102	98 - 107	mEq/L
CO2	23.7	22.0 - 29.0	meq/L
ANION GAP	13	6 - 18	
GLUCOSE	93	70 - 110	mg/dl
BUN	**22 H**	7 - 18	mg/dl
CREATININE	1.1	.8 - 1.3	mg/dl
OSMOLALITY	272	270 - 302	Osm/kg
BUN/CREAT	20	5 - 20	
CALCIUM	**8.5 L**	8.8 - 10.5	mg/dl
ALKALINE PHOS	70	50 - 136	U/L
AST/SGOT	33	15 - 37	U/L
ALT/SGPT	43	30 - 65	U/L
TOTAL BILI	0.47	.00 - 1.00	mg/dl
TOTAL PROTEIN	7.9	6.4 - 8.2	gm/dl
ALBUMIN	4.2	3.6 - 5.0	g/dl
A/G RATIO	1.1	1.0 - 2.0	g/dL
GLOBULIN	3.7	2.0 - 3.7	g/dl
ALCOHOL	**225.8 H**	.0 - .0	mg/dl
MAGNESIUM	2.10	1.80 - 2.40	mg/dl

TDM & TOXICOLOGY

	08/01/05 2254	REFERENCE RANGE	UNITS
AMPHETAMINES	NEGATIVE	Normal:	Negative
BARBITUATES	NEGATIVE	Normal:	Negative
BENZODIAZEPIN	NEGATIVE	Normal:	Negative
COCAINE	NEGATIVE	Normal:	Negative
METHADONE	NEGATIVE	Normal:	Negative
OPIATES	NEGATIVE	Normal:	Negative
PHENCYCLIDINE	NEGATIVE	Normal:	Negative
THC	NEGATIVE	Normal:	Negative
TRICYCLIC ANT	NEGATIVE	Normal:	Negative

Urine Drug Screen is for screening purposes only. Positive results will be sent to the Reference Lab for confirmation.

PALCASTRO SANTANGER E.R.
517533 MCLEOD JIMMY W MD
DOB-05/02/53 52 MALE
08/01/05

Palcastro, Santangero
5-2-53

ER/ROOM

Addressograph

Wiregrass Medical Center
ER Medical Record

( ) Emergent ( ) Urgent (✓) Non-Emergent

Triage Notes: 52 y/o m to ED c/o multiple injuries from resisting arrest. c/o pain (both arms) face & back) (head) Strong smell of ETOH

Time: 2310
Temp: Refused
Tet: (ATD) Wt:
Pulse: 84
Allergies: Iodine
LMP: SpO2:
Resp: 22
Meds: None
BP: 124/74
Nurse Signature: [illegible]

H&P and CC: altercation
PMH: (-)

HPI: 52 y/o male says he was in an altercation c Law enforcement —
Surg: (-)
Social/Habits: drinks

General: WDWN w/m Smell of ETOH
Family Hx:
HEENT: [illegible] — [illegible] laceration on lat. [illegible]
Neuro: physically [illegible] cleared c [illegible]
ROS Neg Document if positive
Heart: RRR
Neuro/Psych: ☐
Lungs: Clear
Cardio/Resp: ☐
Musculoskeletal: no bony Tenderness
GU: ☐
Abd/Rectal: [illegible]
Other: ☐ [illegible]
GU/Gyn:
Ext/Skin: abrasion Rt side of face, Hematoma [illegible] forehead, abrasion occipital scalp - abrasion [illegible]
Dx: Multiple abrasion, laceration, [illegible]

Physician's Orders:	CBC( )	BMP/CMP	ETOH ✓	Medication	Ini
EKG( )	ABG( )	PT/PTT( )	[illegible]		
UA(Rout)(Cath) UDS ✓	CT( ) [illegible] ✓	Amylase( )			
CXR( )	Other Studies [illegible] ✓	US( )			
CM( )	O2( )	Foley( )	IV:		

Disposition: Home(✓) Dr. Office( ) Surgery( ) Expired( ) Adm Rm# AMA/LWBS( ) Date/Time: 0005/8-2-05

Transfer to C/O Dr. Via

Condition at Discharge/Transfer: Improved(✓) Stable(✓) Deteriorated( ) Unchanged( )

Instructions to Pt: (1) Rx: —

(2) Instructions: Neuro checks - Head injury

(3) Follow up: See MD in 3 days

Signing this form denotes that I have reviewed all information on this document and I agree:

Physician's Signature: [signature]

Family Dr. WCD

PALCASTRO SANTANGER E.R.
517833 MCLEOD JIMMY W MD
DOB-05/02/53 52 MALE
08/01/05

ER/ROOM

Addressograph

Wiregrass Medical Center
Emergency Department
Nursing Assessment

Mode of Arrival: ☑ Ambulatory ☐ Stretcher ☐ Ambulance ☐ Arms ☐ Other:_____

Accompanied By: ☐ Self ☐ Family/Friend ☑ Police ☐ Other
Immunizations up to date? ☑ Y ☐ N

Developmental Age Same as Stated Age ☑ Yes ☐ No

How do you prefer to learn? Written ☐ Verbal ☐ Combination ☑

Initial Contact Time: 2210 Allergies: Iodine
Date: 8-1-05

Treatment PTA

None ☑ Cervical Collar ☐ Spineboard: ☐ Splint ☐ Dressings ☐ _____
IV Fluids:_____ Rate: _____ Site: _____
Airway: None ☐ Oral ☐ ET Tube ☐ ☐ Oxygen _____ via ☐ NC ☐ Mask

Nutritional Assessment

Are you on a regular diet? ☐ Y ☐ N
Have you had a recent weight loss or gain? ☐ Y ☐ N
Comments:_____

Respiratory

Respirations: ☐ Regular ☑ Irregular ☐ Shallow ☐ Deep
Breath Sounds: ☑ Bil. Clear ☐ Rhonchi ☐ Rales ☐ Wheezes
Cough: ☐ Productive ☐ Nonproductive
Sternal Retractions? ☐ Yes ☑ No
Dyspnea? ☐ Yes ☑ No
Comments:_____

Circulation

Skin: ☑ Warm ☑ Dry ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy
Color: ☑ Normal ☐ Pink ☐ Dusky ☐ Flushed ☐ Pale ☐ Cyanotic ☐ Jaundice
Edema: ☐ Yes ☑ No
JVD: ☐ Yes ☑ No
Capillary Refill: ☐ Quick ☐ Slow
Comments:_____

Glasgow Coma Scale

Eyes Open:	Spontaneously	4
	To Verbal Command	3
	To Pain	2
	No Response	1
Best Motor Response	Obeys	6
	Localizes Pain	5
	Flexion-Withdrawal	4
	Flexion/Abnormal (Decorticate Rigidity)	3
	Extension (Decerebrate Rigidity)	2
	No Response	1
Best Verbal Response	Oriented/Converses	5
	Disoriented/Converses	4
	Inappropriate Words	3
	Incomprehensible Sounds	2
	No Response	1

GCS Total (3-15): 15

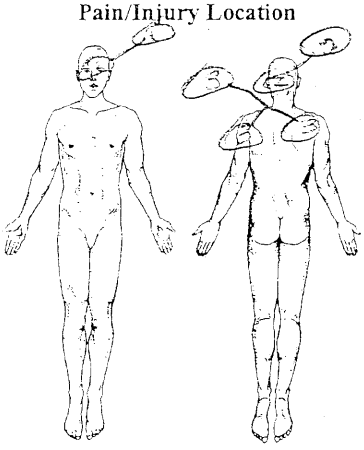
Neurological

Level of Consciousness: ☑ Alert ☐ Responds to Voice ☐ Responds to Pain ☐ Unresponsive ☐ Lethargic
Orientation: ☑ Appropriate Response ☐ Inappropriate Response
Pupils: Brisk ☑ L ☑ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R
Size: L:_____ R:_____
Visual Acuity: ☑ N/A OD:_____ OS:_____
Movement: ☑ Voluntary ☐ Involuntary
Hand Grasp: L ☑ R ☑ Strong; L ☐ R ☐ Weak; L ☐ R ☐ Absent
Slurred Speech? ☐ Yes ☐ No

Abdominal

☐ Distended ☐ Nausea
☐ Vomiting ☐ Diarrhea
☐ Constipation ☐ LBM:_____
Bowel Sounds: ☑ Present ☐ Absent
Comments:_____

Pain/Injury Location



Location (circled above)

Radiation (arrow above)

Laceration (s)

Location(s): Above eye
Size(s): 1cm
Bleeding Controlled: ☑ Yes ☐ No
Comments:_____
Full Range of Motion ☐ Y ☐ N
Pulse:_____ ☐ Y ☐ N
Sensation Intact: ☐ Y ☐ N

GU-GYN

Pain in Voiding: ☐ Yes ☐ No
Frequency ☐ Yes ☐ No
Bleeding: ☐ Yes ☐ No
Vaginal Bleeding ☐ Yes ☐ No
Vaginal Discharge ☐ Yes ☐ No
☐ Scant ☐ Moderate ☐ Large
Grav____ Para____ Ab____
Comments:_____

Orthopedic

Ext Deformity: ☐ Yes ☑ No
Full ROM: ☑ Yes ☐ No
Pulse: +2
Cap. Refill: ☑ Brisk ☐ Slow
Temp: ☐ Warm ☐ Cold
Sensation Intact: ☐ Yes ☐ No

Emotional Assessment

Eye Contact ☐ Y ☐ N
Affect: ☑ Normal ☐ Flat
☑ Cooperative ☐ Disoriented
☐ Combative ☑ Anxious

Do you feel safe in your present living environment?
☑ Yes ☐ No
If no, would you like to talk to someone? ☐ Yes ☐ No
Comments:_____

Pain Cont'd

Severity:_____
0 1 2 3 4 5 6 7 8 9 10
Exacerabated By:_____
Relieved By: ☐ Pt unable to rate

Nurse's Signature

L. Brewer

WIREGRASS MEDICAL CENTER

1200 W. MAPLE AVE.
GENEVA, AL 36340
(334) 684-3655

ED-OP HOME INSTRUCTION SHEET

1. MEDICAL RECORD NO.	2. BILLING NO.	3. A/R NO.

INFORMATION

4. CLASS	5. DATE	6. TIME	7. SRC	8. TYPE	9. SAD

10. PATIENTS LEGAL NAME (L,F,MI)	11. SEX	12. RACE	13. BIRTHDATE	14. AGE	15. HEIGHT	16. WEIGHT	17. SS	18. MS	19.
[illegible] CASTRO SANTANGER		E.R.							

20. RF	21. NOTIFY IN EMERGENCY	22. HOME TELE	23. WORK TELE	24. HOW PATIENT ARRIVED
	517533 MCLEOD JIMMY W [illegible]/02/53 52 MALE			

25. C COMPLAINT 26.	27. PROC CD	28. PROCEDURE	29. LOC	30. TIME	31. ANES
08/01/05					

OUTPATIENT SURGERY INFORMATION

32. PHYSICIAN CALLED	33. ATTENDING PHYSICIAN	34. FAMILY PHYSICIAN
ER/ROOM		

SPRAIN, FRACTURE, & SEVERE BRUISES

- ☐ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort.
- ☐ Ice packs also help prevent swelling, especially during the first 48 hours.
- ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat.
- ☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M.
- ☐ If you have a cast, keep it perfectly dry at all times.
- ☐ Wiggle toes or fingers to help prevent swelling in the cast–this should be done often if it does not cause pain.
- ☐ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly.
- ☐ Use crutches.

BACK AND NECK INJURY INSTRUCTIONS

- ☐ USE HEAT OR COLD ON THE INJURED AREA - whichever seems to help the most. Be careful not to burn yourself.
- ☐ Rest as much as possible until you are improved.
- ☐ Avoid positions and movement that make the pain worse.
- ☐ Relax emotionally - if you are tense the problem will on be worse.
- ☐ Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness.
- ☐ Wear special collar when out of bed.

HEAD INJURY INSTRUCTIONS

Persons who receive blows to the head may have injuries that cannot always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed:

- ☐ Awaken the patient every two hours, even at night, to be sure he knows where he is and is not confused.
- ☐ Check eyes to see that both pupils are of equal size.
- ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol.
- ☐ Restrict excessive work or play.

Call your family doctor or local hospital immediately if the patient:

- ☐ Develops a severe headache.
- ☐ Vomits more than twice within a short time.
- ☐ Is confused, faints or is hard to awaken.
- ☐ Has a pupil of one eye larger that the other
- ☐ Complains of double vision
- ☐ Shows abnormal behavior such as staggering or walking into things.

X-RAY INSTRUCTIONS

Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept.

WOUND CARE (Cuts, Abrasions, Burns, Stitches)

- ☐ Keep the dressings clean and dry.
- ☐ Elevate the wound to help relieve soreness and help speed wound healing.
- ☐ Despite the greatest care, any wound can be infected. If your wound becomes red, swollen, shows pus or red streaks, or feels more sore instead of less sore as days go by, you must report to your doctor right away.
- ☐ Dressing should be changed in _____ days.
- ☐ Treatment rendered _____.
- ☐ Tetanus Toxiod given _____. 250 units of tetanus immune globulin was given. To complete your immunization, you must receive two additional doses of toxoid 4-6 weeks apart. Call your physician for the next dose.
- ☐ Warm soaks to area 4 times daily. 20-40 minutes each time.
- ☐ Continuous warm compresses.

VOMITING & DIARRHEA

- ☐ Do not feed anything for 4 hours.
- ☐ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following: clear liquids, Coke, Gingerale, 7-up, weak tea, Gatorade or Jello, water. If patient is hungrey you may add 1 teaspoon of sugar to each ounce of liquid.
- ☐ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS.
- ☐ The 2 tablespoons of liquid may be offered every hour. If after 4 hours no vomiting has occured, the amount may be slowly increased.
- ☐ Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours.
- ☐ Contact your doctor's office for further instructions after 24 hours.

GENERAL INSTRUCTIONS

- ☐ Stay in bed/may go to bathroom.
- ☐ Use vaporizor.
- ☐ Drink large amounts of liquids.
- ☐ Take _____ aspirin every 4 hours..
- ☐ Avoid any use of injured part.
- ☐ Allow only limited use of the part.
- ☐ You need not necessarily limit activity.
- ☐ Fill Prescriptions given to you from Emergency Dept. and take as directed.
- ☐ No driving or any activity requiring mental alertness after receiving medication.

FEVER OVER 102

- ☐ Sponge with lukewarm water in the tub.
- ☐ If temperature increases or persists for 24 hours, see your family doctor.

EYE INJURY

- ☐ Any eye injury is potentially hazardous.
- ☐ Any increasingly severe discomfort, redness or sudden impairment of vision should be reported immediately to your physician or eye specialist below.
- ☐ Do not drive with eye patch.

ANIMAL OBSERVATION

Instructions for observation of any animal that may have bitten a human if that animal is available for observation.

- ☐ Have animal taken to Vetennarian for observation.
- ☐ If the owner should refuse to take the animal to the Vetennarian, notify the County Health Officer of the situation.

ADDITIONAL INSTRUCTIONS (1) Follow ABOVE HEAD INJURY INSTRUCTIONS (2) NEURO CHECKS EVERY 2-4 HOURS

I hereby acknowledge receipt of all the instructions indicated above. I understand that I have received EMERGENCY treatment only and that I may be released before al my medical problems are known or treated. I will arrange for follow-up care as indicated above. I understand that if my conditions worsen or new symptoms appear, I should contact my Doctor immediately.

PATIENT/PARENT'S SIGNATURE	NURSE'S SIGNATURE	PHYSICIAN'S SIGNATURE
[signature]	[signature] RN	

SCHOOL AND WORK EXCUSE PATIENT NAME DATE

- ☐ No work for _____ days
- ☐ Light work for _____ days
- ☐ May return to work on _____
- ☐ No school for _____ days
- ☐ No Physical Education for _____ days
- ☐ May return to school on _____

WIREGRASS MEDICAL CENTER

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

NAME: Santangelo Palcastro SOC. SEC. NO: 096 44 7848

IDENTIFICATION NO: 517533 DATE OF BIRTH: 5-2-1953

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

1. I have been given written materials about my right to accept or refuse medical treatments

2. I have been informed of my rights to formulate Advance Directives.

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☑ **I HAVE NOT** executed an Advance Directive.

Signed: Patient's mark Date: 8-1-05

Witness: _____ Date: _____

Witness: Vicki Bart Date: _____

Sam Barnes RN

Form # 390 Advance Directive Acknowledgement

PALCASTRO SANTANGER E.R
517533 MCLEOD JIMMY W MD
DOB-05/02/53 52 MALE
08/01/05

ER/ROOM

Wiregrass Medical Center
Emergency Physician's Charge Sheet Date:

Level of Service	
19599281	Level I
19599282	Level II
19599283	Level III
19599284	Level IV
19599285	Level V
19599288	Direct Life Support In Transit
19599025	Visit with Surgery
19599291	Critical Care per Hour
19599292	Critical Care per 1/2 hour
19591105	NG Lavage/Aspiration
19599175	Ipecac Admin/Observe Gastric emptying
Airway/Pulmonary	
19531500	Endotracheal Intubation
19531511	FB Removal
19532020	Tube Thoracostomy
Vascular Procedures	
19536410	Non-Routine Venipuncture
19590780	IV Therapy Requiring MD per hour
19592977	Thrombolysis IV infusion
Cardiac Procedures	
19592950	CPR
19592953	Transcutaneous Pacing
19592960	Cardioversion, Elective
19593010	EKG Interpretation
Ophthalmology	
19565205	FB
19565210	FB Conjunctival/Embedded
19567938	FB, Eyelid
Ear,Nose, and Throat	
19542809	FB Pharynx
19569200	FB External Ear Canal
19569210	Impacted Cerumen
19530300	FB Intranasal
19530901	Anterior Epitaxis, Simple
19530903	Anterior Epitaxis, Complex
19530905	Posterior Epitaxis, Initial
Soft Tissue/Foreign Body Removal	
19510120	Sub Q, Simple
19510121	Sub Q, Complicated
19520520	Muscle, Simple
19520525	Muscle, Complex
Nails	
19511730	Avulsion/Nail, Simple
19512740	Subungal Hematoma

Debridement	
19511000	Infected Skin
19511040	Partial Skin Thickness
19511041	Skin, Full Thickness
19511042	Skin and Sub Q Tissue
19511043	Skin, Sub Q, Muscle
19511044	Skin, Sub Q, Muscle, Bone
Hematoma and Abcess	
19510060	I&D Simple Abcess, Furuncle
19510061	I&D Simple Abcess, Complicated/ Multiple
19510140	I&D Hematoma Simple
19510160	I&D Puncture Aspiration, Abcess
19546320	Hemorrhoid, Thrombosed
Burns	
19516000	First Degree Burn, Initial
19516020	Small Burn, Debride,Dress
19516025	Medium Burn, Debride/Dress
19516030	Large Burn, Debride/Dress
OB/GYN Procedures	
19556405	I&D, Abcess, Vulva
19556420	I&D, Bartholin Abcess
19559410	Emergency Vaginal Delivery
Arthrocentesis	
19520600	Arthrocentesis, Small Joint
19520605	Arthrocentesis, Intermediate Joint
19520610	Arthrocentesis, Major Joint
Miscellaneous Fractures	
19521800	Closed Rib Fracture
19523500	Clavicle
19523720	Closed Phalangeal Shaft
19526750	Closed Distal Phalangeal
19528490	Closed Fracture, Great Toe
19528510	Closed Phalanx other than Gr. Toe
Miscellaneous Closed Dislocations	
19521480	TMJ Uncomplicated
19523650	Shoulder w/ Manipulation
19524640	Nursemaid's Elbow
19526700	Finger, MP Joint
19526770	Finger, IP Joint
19528660	Toe IP Joint
Miscellaneous Procedures	
19553670	Urine Catheterization, Simple
19553675	Urine Catheterization, Complex
19562270	Spinal Puncture
19564450	Digital Block
19582270	Stool for Occult Blood
19593042	Rhythm Strip Interpretation
Repair/Simple- Single Layer	
Scalp, Neck, Axillae, External Genitalia, Trunk, and/or extremities	
19512001	2.5 cm or less
19512002	2.6 - 7.5 cm
19512004	7.6 - 12.5 cm
19512005	12.6 - 20.0 cm

Repair/Simple- Single Layer Cont'd	
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512011	2.5 cm or less
19512013	2.6 - 5.0 cm
19512014	5.1-7.5 cm
19512015	7.6 - 12.5 cm
19512016	12.6 - 20.0 cm
19512017	20.1 - 30.0 cm
19512018	Over 30.0 cm
19512020	Superficial WD Dehis
19512021	Superficial WD Dehis-Pack
Repair/Intermediate-Layered	
Scalp, Axillae, Trunk, and/or Extremities	
19512031	2.5 cm or less
19512032	2.6 - 7.5 cm
19512034	7.6 - 12.5 cm
19512035	12.6 - 20.0 cm
19512036	20.1 - 30.0 cm
19512037	Over 30.0 cm
Neck, Hand, Feet, and/or External Genitalia	
19512041	2.5 cm or less
19512042	2.6 - 7.5 cm
19512044	7.6- 12.5 cm
19512045	12.6 - 20.0 cm
19512046	20.0 - 30.0 cm
19512047	Over 30.0 cm
Face, Ears, Eyelids, Nose, Lips, and/or Mucous Membranes	
19512051	2.5 cm or less
19512052	2.6 - 5.0 cm
19512053	5.1 - 7.5 cm
19512054	7.6 - 12.5 cm
19512055	12.6 - 20.0 cm
19512056	20.1 - 30.0 cm
19512057	Over 30.0 cm
Repair/Complex-Reconstructive or Complicated Wound Closure	
Trunk	
19513100	1.1 - 2.5 cm
19513101	2.6 - 7.5 cm
Scalp, Arms, and/or Legs	
19513120	1.1 - 2.5 cm
19513121	2.6 - 7.5 cm
Forehead, Cheeks, Chin, Mouth, Neck, Axillae, Genitalia, Hands, and or Feet	
19513132	1.1 - 7.5 cm
Eyelids, Nose, Ears, and/or Lips	
19513151	1.1 - 2.5 cm
19513152	2.6 - 7.5 cm

PALCASTRO SANTANGER E.R.
517533 MCLEOD JIMMY W MD
DOB-05/02/53 52 MALE
08/01/05

ER/ROOM

Wiregrass Medical Center
ER Level of Service Charge Sheet

		Circulatory
		Jugular,Cutdown, Central Line
	19636430	Blood Administration
	19692960	Cardioversion, Mechanical
	19692950	Code Blue
	19692953	External Pacemaking
	19631500	Intubation
	19690471	Vacine Admin. (other than Rabies)
	19690675	Vacine Administration (Rabies)
	19690784	Medication Administration IV
	19690782	Medication Administration IM or SQ
	19690780	IV infusion-up to 1 hour
	19690781	IV infusion-each additional hour
	19649080	Paracentesis
		Peritoneal Lavage/Tap
	19632000	Thoracentesis
	19633010	Pericardiocentesis
	19632002	Chest Tube Insertion
		IV Hydration
		ENT
		Eye Irrigation
		Eye Exam/Corneal Abrasion
		Foreign Body Removal Ear
		Foreign Body Removal Nose
		Irrigation Ear
		Nose Bleed/Nasal Packing
		Rust Ring (Foreign Body Removal)
		Respiratory
	19631603	Tracheotomy
	19631605	Cricothyrotomy
	19631603	Trach Change
		Gastrointestinal
	19691105	Gastric Lavage or NGT insertion
	19643760	Gastrostomy Tube Placement
		Genitourinary
	19659409	Delivery/Birth
		Supra Pubic Cath, or Turkey Tray
	19651700	Irrigation of Catheter
		Pelvic Exam

		Integumentary
	19611760	Repair of Nail Bed
	19611740	Subungal Hematoma
		Dressing Application
	19610120	FB removal
	19620000	I&D Abcess
	19600000	Laceration Repair (simple,intermed)
	19610000	Laceration Complex
	19611040	Debridement
	19616020	Treatment of Burns
		Orthopedics
		Behr Block/Regional Block
	19629500	Casting/Splinting
	19629705	Removal or Revision of Cast
		Tx of fx/dislocation with manipulation
	19620950	Compartmental Syndrome
		Neurological
	19662290	Lumbar Puncture
		Other
	19682962	Glucose fingerstick
		Treatment Level
	19699211	Low Level E/R
	19699281	Emergency WD
	19699282	Emergency I
		Emergency I with procedure
✓	19699283	Emergency II
		Emergency II with procedure
	19699284	Emergency III
		Emergency III with procedure
	19699285	Emergency IV
		Emergency IV with procedure
	19699291	Critical Care
		Critical Care with procedure
		Observation I
		Observation II
		Observation III

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE GENEVA AL 36340

EMERGENCY ROOM • OUTPATIENT RECOR

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
519327	2	PALCASTRO JOHN PHILLIP	52	5/02/1953	M	SW	8/25/05	14:39	GDC

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
405 W WASHINGTON		SAMSON	AL	36477	334-684-5670

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
096447848	NONE GIVEN			

INSURANCE COMPANY	CONTRACT OR GROUP NUMBER	DATE	PLACE
		8/01/05	HOME/OTHER ACCID
		TIME	EVENT
			FACIAL CONTUSIO

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
PALCASTRO JOHN PHILLI	405 W WASHINGTON	SAMSON	AL	36477	684-5670

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
INMATE AT CO JAIL			

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/2ND PHYSICIAN
517533	8/01/05		096447848	MITCHUM O /

CHARGES	X-RAY	LAB	RESP. TH.	PHY. TH.	EKG	I.V.	DRUGS	SUPPLIES	OTHER	M.D.	E.R. RM	TOTAL DUE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT , ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and employees of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained.
2. The undersigned agrees to pay for services rendered by Hospital upon release of patient.
3. I/we hereby assign any hospital benefits, sick benefits, injury benefits due to a liability of a Third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient.
4. I/we hereby authorize the 'Administrator of Hospital' to furnish from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby appoint the 'Controller' of Hospital as my lawful attorney to endorse for me any checks made payable to me for benefits or claims collected under the above assignment and to apply any credit balance to any other account I may owe said hospital.

DATE TIME SIGNED PATIENT SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

NURSE'S SIGNATURE (RN OR LPN)

LAB DATA (Including X-Rays, EKGs, etc.)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

CONDITION ON DISC		
IMP	STABLE	EXPIRED

INSTRUCTIONS TO PATIENT:

FOLLOW-UP WITH

M.D.

M.D.

Wiregrass Medical Center
1200 W. Maple Avenue
Geneva, Alabama 36340

Palmertree John P.

CONDITIONS FOR TREATMENT

1. **MEDICAL AND SURGICAL CONSENT FOR TREATMENT:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.

2. **RELEASE OF INFORMATION:** The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.

3. **RELEASE FROM LIABILITY FOR VALUABLES:** I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.

4. **GUARANTOR AGREEMENT:** The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.

5. **ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Date 8/25 20 05

Witness Gloria Cox

Patient

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS:
PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date | Signature | Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

Date | Signature | Relationship to Patient

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

P

Patient Name..... PALCASTRO, JOHN P.

Admission Date..... 08/25/2005

Medical Record Number..... 096447848

Age..... 52

Account Number..... 519327

Discharge Date..... 08/25/2005

Date of Birth..... 05/02/1953

Sex..... Male

DX	Code	DX Description
1	923.00	Contusion of Shoulder Region
2	920	Contusion of Face/Scalp/Neck Excl Eye

PR	Code	PR Description	Procedure Date	Surgeon

CPT	Code	CPT Modifiers	CPT Description	CPT Date	CPT Surgeon
		APC PSI	Payment Rate	ASC Group	ASC Fee

Attending Physician..... MITCHUM O D

Consulting Physician.....

Discharge Disposition..... 01 - Home

DRG =

Status.....

Memo

DRG

MDC Weight AMLOS GMLOS LOS

WIREGRASS MEDICAL CENTER

1200 WEST MAPLE AVENUE
GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: PALCASTRO JOHN PHILLIP
AGE: 52 SEX: M
DOB: 05/02/1953
STAY TYPE: O/P ROOM:
ADMIT DATE: 08/25/05
ACCT NUMBER: 519327
LOCATION:
TRANS DATE: 8/26/05

PATIENT PHONE: 334/684/5670
ORDERING PHY: MITCHUM O
ADMITTING PHY: MITCHUM O
REFERRING PHY:
FAMILY PHY:
XRAY NUMBER: 24044
MR NUMBER: 096447848
TRANS INITIALS: SR

<=X-RAY ORDER=> COMPLETE:08/25/05 14:49 NAP 22637
Reason for Procedure: CONTUSION
FACIAL BONES MIN.3V 70150 COMPLETE:08/25/05 14:49 NAP 22641
SHOULDER MIN 2V 73030 COMPLETE:08/25/05 14:49 NAP 22642

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

LEFT SHOULDER 2 VIEWS: THE AC JOINT IS INTACT. THERE IS NO DEFINITE FRACTURE OR DISLOCATION IDENTIFIED.

OPINION: UNREMARKABLE EXAM.

FACIAL BONES: THE ORBITS ARE INTACT AND THERE IS NO DEVIATION OF THE NASAL SEPTUM. THE SINUSES ARE WELL AERATED. THERE ARE NO DEFINITE FRACTURES IDENTIFIED.

OPINION: UNREMARKABLE EXAM.

JOHN C. TOMBERLIN, M.D.

Wiregrass MEDICAL CENTER

1200 West Maple Ave.
Geneva, Alabama 36340
334-684-3655 voice
334-684-3558 fax

Patient Name

SS# | DOB

Phone | Precertification #

Physician Signature /Date

Diagnosis
(Essential for registration)

STAT & Call Results | Fax to # | Send Results by Courier | Results by Mail

Laboratory

Amylase	Lipid Profile	RA Profile
ANA	Hepatic Panel	RA Test
B12/Folate	Mono test	Sed. Rate
Calcium	Phenobarbital	SGOT
CBC	Potassium	Tegretol Level
Cholesterol	Pregnancy-Urine	Theophylline
Culture	Pregnancy-Serum	Thyroid Profile
Depakote Level	Basic Metabolic	Triglycerides
Digoxin Level	Comp Metabolic	Lithium
Dilantin Level	Pro Time	Urine Culture
Glucose	PSA	Urinalysis
Hgb A1C	PTT	

Other as follows:

Imaging Services

Ultrasound	CT	Contrast Yes	Contrast No	Nuclear Med
Abdomen	Abdomen			Bone
Arterial	Head			Hida
Breast	Pelvis			Thyroid
Carotid	L. Spine			
Echo	C. Spine			
Retroperitoneal				
Pelvis				
Venous				

Other as follows:

X-Ray

L	R		L	R	
		Ankle			Humerous
		Clavicle			Femur
		Chest			G.I.
		Elbow			Finger (Specify digit)
		Foot			Toe
		Foot & Ankle			Knee
		Forearm			Pelvis
		Hand		X	Shoulder
		Hip			Wrist
		Lumbar Spine			Cervical Spine
		Mammogram-Screening			Tib-Fib
		Mammogram-Diagnostic			

Other as follows: Facial bones

Respiratory Care

ABG	Pulmonary Function
Pulse Oximetery	Basic
	Complete
	With bronchodilator
	Without bronchodilator

Other as follows:

Physical Therapy

Evaluate & Treat	Tens Unit
Modalities	Traction
Gait Training	Whirlpool/Wound Care
Prosthetic Training	Strengthening/ROM Exercise

Other as follows:

Cardiology & Neurological Services

EKG	GXT	GXT-Thallium
Holter	2-D Echo	2-D Doppler
EEG	Stress Echo	

Other as follows: